ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Blood Banks, Home Health Agencies, Individual Medical Supply Providers, Medical Equipment Vendors, Nurses in Independent Practice, Nursing Homes, Personal Care Agencies, Pharmacies, HMOs and Other Managed Care Programs

Durable Medical Equipment Covered Under the BadgerCare Plus Basic Plan

The Department of Health Services will begin accepting applications for enrollment in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. This *ForwardHealth Update* describes the coverage and policies for durable medical equipment under the Basic Plan.

Refer to the June 2010 *Update* (2010-42), titled "Introducing the BadgerCare Plus Basic Plan," for general information about covered and noncovered services, reimbursement, copayment, and enrollment.

Overview of BadgerCare Plus Basic Plan Implementation

In October 2009, enrollment in the BadgerCare Plus Core Plan was closed. Enrollment applications submitted to the Core Plan after the cutoff date are not processed, but the individuals are put on a waitlist.

Individuals on the waitlist for the Core Plan can begin enrolling in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. The Basic Plan is a self-funded plan that focuses on providing the Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan will be covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Covered and Noncovered Services

Durable medical equipment (DME) covered under the Basic Plan is the same as the DME covered under the Core Plan, including preferred blood glucose meters. Non-preferred diabetic supplies are not covered under the Basic Plan. Cochlear implants and bone-anchored hearing devices are not covered under the Basic Plan.

Refer to the Online Handbook on the ForwardHealth Portal for policies and procedures related to covered DME.

Service Limitations for the Basic Plan

The Basic Plan will reimburse up to $500.00 for DME per member per enrollment year. The cost of DME repairs counts toward this service limitation. The cost of blood glucose meters do not count toward this service limitation.

Durable medical equipment that exceeds the $500.00 service limitation is considered noncovered.

Prior Authorization

Prior authorization is not required for DME under the Basic Plan. Prior authorization is not accepted for non-preferred diabetic supplies.

Reimbursement

Providers will be reimbursed for DME provided to Basic Plan members at the lesser of the provider's usual and customary charge or the established maximum allowable fee until the member reaches his or her service limitation of $500.00 per year.

If BadgerCare Plus covers any portion of the DME charges, providers are required to accept the BadgerCare Plus-allowed reimbursement, which is the lesser of the provider's usual and customary charge or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, suppose the BadgerCare Plus-allowed reimbursement for a DME item is $150.00 and the member has expended $400.00 of his or her DME coverage for the enrollment year. BadgerCare Plus will reimburse only $100.00 before the member has exhausted his or her coverage. The member is responsible for the additional $50.00. The provider must still accept $150.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $50.00.

If a member has already met or exceeded his or her DME service limitation, BadgerCare Plus will not reimburse providers for DME provided to that member. The provider may collect his or her usual and customary charge from the member.

Terms of Reimbursement

The DME terms of reimbursement (TOR) have been revised for the Basic Plan. Refer to the Attachment of this *Update* for the Medical Supply and Equipment Vendor Terms of Reimbursement, F-1056. The TOR describes how BadgerCare Plus will reimburse providers for services rendered. The conditions outlined in the TOR will automatically take effect; providers do not need to resubmit certification materials.

Copayments

Copayment for most DME covered under the Basic Plan is up to $10.00 per item with no monthly or annual limits.

Copayment for blood glucose meters is $0.50 per prescription.

If the reimbursement amount for an item is less than the copayment amount, the member should be charged the lesser amount as copayment.

Note: Rental items and repairs are not subject to a copayment.

Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Enrollment Year Under the Basic Plan

The Basic Plan enrollment year is the time period used to determine service limitations for members in the Basic Plan.

The Basic Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (the first day of the month) in the Basic Plan and ending on the last day of the 12th full calendar month.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Enrollment Verification

The Basic Plan offers different covered services, noncovered services, and copayments than the Standard Plan, the Benchmark Plan, or the Core Plan. It is imperative that providers verify a member's enrollment and determine the plan under which he or she is covered. Providers are reminded to *always* verify a member's enrollment *before* providing services to determine enrollment at the current date (since a member's enrollment status may change) and discover any limitations to the member's coverage.

For More Information

For more information or questions regarding the Basic Plan, providers may call Provider Services at (800) 947-9627.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ATTACHMENT
Medical Supply and Equipment Vendor Terms of Reimbursement

(A copy of the "Medical Supply and Equipment Vendor Terms of Reimbursement" is located on the following page.)

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MEDICAL SUPPLY AND EQUIPMENT VENDOR TERMS OF REIMBURSEMENT

The Department of Health Services (DHS) will establish maximum allowable fees for all covered durable medical equipment (DME) and disposable medical supplies (DMS) provided to Wisconsin Medicaid and BadgerCare Plus members eligible on the date of service.

The maximum allowable fees for DME and DMS shall be established upon a review of various factors. These factors include a review of usual and customary charges submitted to Wisconsin Medicaid and BadgerCare Plus; cost, payment, and charge information from companies that provide DME and DMS; Medicaid payment rates from other states; and the current Medicare fee schedule. Other factors taken into consideration include the Wisconsin State Legislature's Medicaid budget constraints, limits on the availability of federal funding as specified in federal law, and other relevant economic and reimbursement limitations. Maximum allowable fees may be adjusted periodically.

Providers are required to bill their usual and customary charges for equipment, supplies, and services provided. The usual and customary charge is the amount charged by the provider for the same equipment, supplies, or services when provided to non-Medicaid patients. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the product or service when provided to non-Medicaid patients.

Covered DME and DMS shall be reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by the DHS. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

Under the BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan , and BadgerCare Plus Basic Plan, DME charges shall be reimbursed by the DHS up to the member’s coverage limit. When BadgerCare Plus reimburses the provider for any portion of the DME charges, the provider may balance bill the member for the remainder of the BadgerCare Plus-allowed reimbursement rate. This will be considered payment in full.

The DHS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.

Payments for deductibles and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(c), Wis. Stats.

In accordance with federal regulations contained in 42 CFR 447.205, the DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

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